Statement of

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Tax Code and Health Insurance Coverage

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Chairman Spratt, Ranking Member Ryan, and members of the committee: Thank you for inviting me to discuss the role of the tax system in expanding access to health insurance. This hearing is extremely timely. About 47 million Americans under age 65, including 9 million children, lack health insurance. They are less likely to get important preventive screenings while healthy, and they receive lower-quality care when sick.[1] And, the public ultimately shoulders the burden of paying for the medical treatment of those lacking insurance, through higher taxes or higher health care costs.

The recent debate over the State Children's Health Insurance Program (S-CHIP) has focused on the best way to cover uninsured children, and many, including the president, have suggested that the tax system is the answer. I'd like to focus on the potential and limitations of using tax credits to expand coverage, as that is the only feasible way to use the tax system to help lower-income households obtain health insurance. Mr. Ryan has cosponsored a bill, H.R. 914, to provide a refundable credit up to $4,000 per year to help lower-income households purchase insurance in the individual nongroup market, similar to an earlier proposal from President Bush.

In considering such options, it is best to keep in mind Hippocrates' dictum: "Do no harm." A carefully designed program of health insurance tax credits combined with effective reforms of the market for nongroup health insurance *could* significantly expand health insurance coverage, although potentially at very high cost per newly insured person. And proposals to subsidize nongroup insurance alone with no meaningful provisions to fix the inherent failings in the nongroup health-insurance market would cause millions of Americans to lose their health insurance coverage. Those who suffer from chronic health conditions or have low incomes would be most vulnerable.

My testimony briefly summarizes the current tax treatment of health insurance, the effects of tax subsidies on coverage and health care costs, discusses ways that tax credits might affect health care coverage, and concludes with some recommendations.

Tax Subsidies for Health Insurance

Because the tax system heavily subsidizes employer-sponsored insurance (ESI), most nonelderly Americans get their health insurance at work. Employer contributions to employee health insurance are treated as nontaxable fringe benefits and are not considered part of total compensation for income or payroll tax purposes. The tax subsidies for ESI reduced income and payroll tax receipts by as much as $200 billion in fiscal year 2007.

Section 125 of the Internal Revenue Code allows employers to set up so-called cafeteria plans for administering certain employee benefits. A cafeteria plan allows employees to choose to receive part of their compensation either as cash wages or as one or more nontaxable fringe benefits, including health insurance. Flexible spending accounts (FSAs) are similar to cafeteria plans. They allow employees to set aside a fixed dollar amount of annual compensation to pay for out-of-pocket expenses for medical and dental services, prescription drugs and eyeglasses, and the employee's share of the cost of employer-sponsored health insurance. An FSA is financed through regular salary reductions. Any amount unspent at the end of the year is forfeited to the employer.[2] Employees pay no income or payroll taxes on the medical-related benefits paid through a cafeteria plan or FSA. As a result, employees with access to such plans may pay for all or most of their medical costs with pretax dollars.

Employers may purchase insurance for their employees or provide insurance themselves (i.e., self-insure—typically, in a plan managed by a third-party administrator). Section 105 of the Internal Revenue Code sets out nondiscrimination rules for benefits provided by self-insured plans. These rules aim to prevent highly compensated managers from providing generous tax-free benefits for themselves that are not available to the rank-and-file workers.[3] The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandates and health insurance premium taxes that apply to third-party insurers.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA to require employers with 20 or more employees who provide health insurance (whether self-insured or not) to allow participants and other beneficiaries (i.e., family members) to purchase continuing coverage for at least 18 months after it would otherwise cease for any reason, including termination, death, or divorce. Employers can charge covered employees their premium cost plus 2 percent for continuation of coverage. Workers who become disabled may retain coverage beyond the 18-month period by paying a premium up to 150 percent of the employer's average cost.

The Trade Adjustment Assistance Reform Act of 2003 created a 65-percent refundable tax credit for health insurance purchased by workers certified by the Department of Labor as having lost their jobs due to foreign competition. Workers

covered by a pension taken over by the Pension Benefit Guaranty Corporation also qualify.

Most individuals who purchase their own insurance directly, whether through COBRA or not, cannot deduct the cost. However, individuals may deduct the portion of premiums they pay for health insurance plus other medical expenses that exceed 7.5 percent of adjusted gross income (AGI).[4] In addition, the self-employed may deduct their health insurance premiums from income tax (though not payroll tax) if they do not have access to ESI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a four-year pilot program to make Medical Savings Accounts (MSAs) available to a limited number of people who are self-employed or work for small firms. The Medicare Prescription Drug Improvement and Modernization Act of 2003 renamed MSAs Health Savings Accounts (HSAs) and made them available to workers regardless of firm size. The Tax Relief and Health Care Act of 2006 modified the rules on annual contributions that could be made to an HSA. To qualify, individuals must be under age 65 and covered by a high-deductible health insurance plan, either offered at work or purchased in the nongroup market. The deductible must be at least $1,100 for single coverage and $2,200 for family coverage. The out-of-pocket maximums are limited to $5,500 and $11,000 for single and family coverage, respectively. The individual may contribute up to $2,850 for single coverage and $5,650 for family coverage into the HSA, regardless of the deductible.[5] Employer contributions to an employee's HSA up to those limits minus any employee contribution are excluded from taxable income for both income and payroll tax purposes—just as contributions to ESI are. Individuals' contributions to an HSA are deductible for income tax purposes.[6] Individuals age 55 to 64 may make additional "catch-up" contributions of up to $800 in 2007.[7] Balances in an HSA may be withdrawn to pay for qualifying medical expenses without penalty; nonmedical withdrawals are subject to income tax, and withdrawals made before age 65 are subject to an additional 10 percent penalty. Unspent balances in an HSA accumulate tax-free.

These supplemental tax subsidies for health insurance are small compared with the exclusion for employment-based health insurance. They reduced income tax revenues by an estimated $13 billion in fiscal year 2007. In contrast, the employer exclusion reduced income tax revenues by between $106 and $141 billion in the same year.[8] Including payroll taxes, the total revenue loss could exceed $200 billion per year.[9]

Effects of Tax Subsidies on Health Insurance Coverage

The tax subsidy for ESI has produced mixed results. Although it has undoubtedly allowed millions of Americans to get insurance, it is a flawed subsidy mechanism. On one hand, excluding employer contributions toward health insurance is administratively quite simple. Employers do not need to measure and allocate premiums to include in employees' income.

On the other hand, the ESI exclusion is an upside-down subsidy. The largest subsidies go to high-income taxpayers who would be most likely to obtain insurance

under almost any system. Those with low incomes get little or nothing. The subsidy for ESI depends on the marginal income tax rate, which increases with income. Taxpayers in the highest income tax bracket (35 percent) save 35 cents in income taxes for every dollar of earnings received in the form of health insurance. The roughly 30 percent of low-income households in the zero tax bracket, in contrast, receive no income tax benefit. (They might save payroll taxes, but that is a mixed blessing since their reduced payroll contributions to Social Security produce a commensurate drop in retirement benefits.) The result is a system in which households that face the highest premium burden as a share of income receive the smallest subsidy rate (figure 1).

**Figure 1. An Upside Down Subsidy:
Projected Tax Subsidy Rate Versus Premium Burden
for Families with ESI, by Income, 2009**
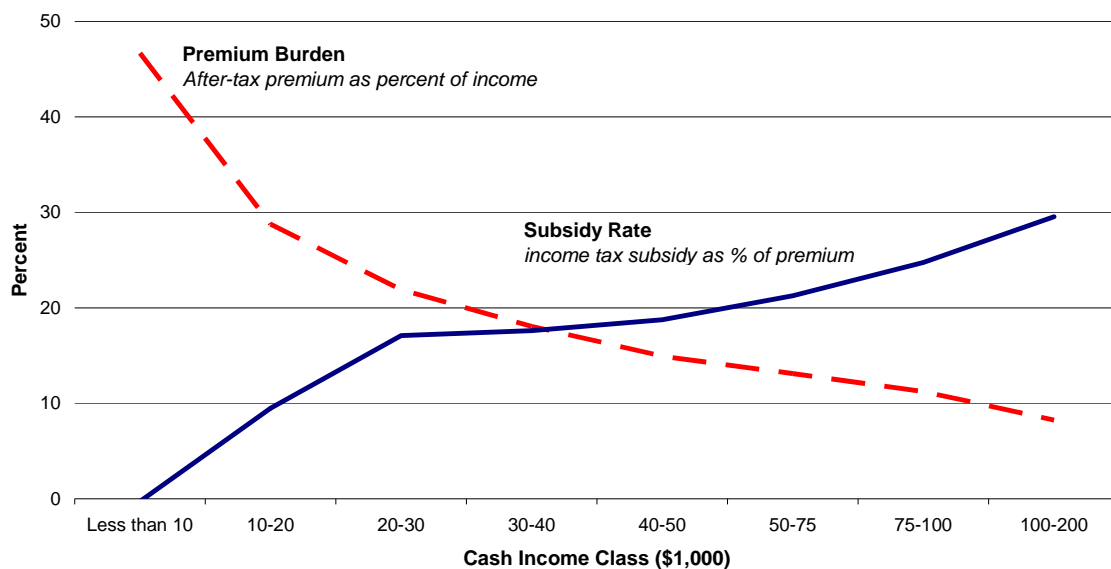
Note: Subsidy includes income tax and Medicare payroll tax savings. See Burman et al (2007) for discussion.

There are also advantages and disadvantages to tying health insurance to employment. The main advantage of subsidizing ESI is that employment is a natural way to pool health insurance risks since people choose employment for many reasons other than their expected use of health care. Employment pooling works best for large firms, but Pauly and Herring (1999) claim that even relatively small groups can effectively pool most risks. But Cutler (1994) found evidence of large year-to-year variation in average health expenditures in small groups, which creates a substantial risk of large premium increases in small firms.

Another advantage with large groups is that administrative and marketing costs are lower (Monheit, Nichols, and Selden 1995). Collecting premiums as a part of payroll processing is less expensive than direct billing. Collecting insurance premiums, either explicitly or implicitly as a part of payroll processing, may also be an especially effective way to encourage participation because individuals like to break up large expenses into small, automatically collected pieces (Thaler 1992). Also, participation rates are higher if

the choice workers face is framed in terms of opting out rather than opting into an insurance plan. Large groups also have bargaining power to lower costs when dealing with insurers and providers. And, to the extent that workers can count on long-term employment with an established firm, ESI may provide more protection against premium increases than does the individual market.

But ESI has drawbacks as well. It is an imperfect pooling mechanism. In a small firm, if one person gets sick, average costs can jump. Also, ESI provides limited renewability at best. People can lose their jobs or employers can decide to drop coverage—for example, because of unacceptably large premium increases.[10] Although no better mechanism for pooling or renewability currently exists in the individual market, such a mechanism might have arisen were it not for the large tax subsidy for ESI. For example, if professional associations, unions, or religious institutions were subsidized, they might also offer group health insurance policies to their members, much as they do with life insurance (Pauly and Herring 2001).

Finally, the subsidy for ESI amplifies the advantage of large firms over small ones as payers for health insurance. To see why, imagine a world without a tax exclusion for ESI. Many large firms might still offer health insurance even without a tax subsidy because of their advantages in pooling and lower administrative costs. Few, if any, small firms would. Now, after a tax exclusion is introduced, taxes fall for employees of firms that offer health insurance, but not for employees of other firms. Firms that do not offer health insurance now would face pressure from their employees to offer this valuable tax-free fringe benefit, and many would do so, but their compensation costs would increase relative to the large firms because, for a given package or benefits, health insurance is more expensive for small firms. The higher benefit costs place smaller firms at a competitive disadvantage. Effectively, the tax exclusion for ESI is a differential labor subsidy that is most valuable to large firms. It distorts the allocation of labor in favor of large firms and reduces production efficiency because workers who might be more productive at small firms are induced to shift to large firms by the tax subsidy.

The subsidy for ESI also creates other inefficiencies. It gives employers an incentive to outsource low-income and younger workers (who would not value the insurance as much) and distorts workers' decisions about work and retirement (CBO 1994).

For all its imperfections, however, ESI covers almost 70 percent of American workers (table 1). Not surprisingly, higher-income workers are much more likely to be covered by ESI than those with lower incomes. About 45 percent of workers with incomes under $20,000 were covered by ESI, compared with 86 percent of workers with incomes over $40,000. Full-time, full-year workers were much more likely to get ESI than part-time or part-year workers. And workers at large firms were much more likely to be covered by ESI than those working for small firms. Nonetheless, more than half of employees at small firms (fewer than 25 employees) were covered by their own or their spouse's ESI. More than 30 percent were covered by their own employer (not shown in table). This raises important concerns about policies that would cause more small employers to stop offering coverage.

Table 1. Primary Source of Health Insurance for Workers Age 18 to 64, by Demographic Category, 2006

| | Workers (millions) | Percent Distribution by Coverage Type | | | | |
| | | Private | | Public | | Uninsured |
		Employer	Individual	Medicaid	Other	
Total—Workers	147.1	69.8	5.7	4.6	1.1	18.8
Age						
18–34	53.7	59.0	6.7	7.0	1.0	26.3
35–54	71.7	75.4	4.7	3.5	0.9	15.5
55–64	21.7	77.6	6.4	2.6	2.3	11.1
Worker's Annual Income						
<$20,000	41.3	45.2	8.1	19.4	1.7	34.6
$20,000–$39,999	46.7	70.5	4.9	3.8	1.1	19.7
$40,000+	59.1	86.3	4.6	1.3	0.8	7.0
Family Poverty Level						
<100%	12.8	20.8	9.4	18.5	1.4	49.8
100–199%	23.3	41.6	7.0	9.7	1.5	40.2
200–299%	24.3	66.2	5.9	3.9	1.5	22.5
300–399%	20.5	79.0	5.4	2.1	1.0	12.5
400%+	66.2	87.6	4.5	1.2	0.9	5.8
Work Status						
Full-time/Full-year	104.0	76.1	4.3	2.8	0.8	16.0
Full-time/Part-year	18.6	55.0	6.2	8.7	1.5	28.7
Part-time/Full-year	12.9	57.2	11.2	7.4	1.5	22.3
Part-time/Part-year	11.6	50.5	10.9	12.0	2.9	23.6
Business Size (# Workers)						
Self-employed	13.5	47.9	18.9	4.1	1.5	27.6
<25	29.6	51.8	7.8	6.3	1.2	33.0
25–99	17.8	68.3	4.7	4.9	1.1	21.1
100–499	17.3	75.0	3.3	4.4	0.7	16.6
500–999	6.6	79.2	2.7	4.8	0.6	12.7
1,000+	41.0	78.1	3.3	4.5	1.0	13.0
Public sector	21.0	86.9	2.5	2.9	1.6	6.2

Although some analysts believe that a better mechanism would arise if there were no ESI, there is a risk that major tax changes could significantly reduce insurance coverage. Removing or reducing employers' incentives to sponsor health insurance would have mixed effects on coverage. While some young, healthy people might be induced to acquire coverage in the individual nongroup market under a different set of incentives, the loss of ESI could be particularly devastating to old and unhealthy workers who would face prohibitively high health insurance premiums in the private nongroup market in the vast majority of states.

Tax Credits for Nongroup Health Insurance

Although ESI and public programs cover most Americans, 47 million Americans lack health insurance. Subsidizing the purchase of private nongroup insurance for those who cannot obtain it at work seems a natural remedy, but it might actually do more harm than good.

The appeal of tax credits for nongroup health insurance is obvious. It seems unfair to limit tax subsidies to those who get insurance at work. And most uninsured people do not have access to employment-based health insurance, so the only effective way to subsidize them would seem to be through the nongroup market, a public program such as S-CHIP or Medicaid, or new state- or federally subsidized purchasing pools.

Health credit advocates also believe that moving more consumers into the nongroup market would unleash competitive forces that would constrain health care costs. Insurers, competing for business, would find new and innovative ways to limit health spending while providing a product that people value. Health care consumers, for their part, when faced with more responsibility for health care costs, would put pressure on providers to avoid unnecessary tests, therapies, and drugs.

On its face, I'm very attracted to these arguments. As an economist, I live in awe of well-functioning markets. It is a marvel that a completely decentralized process whereby agents all over the world, acting completely in their own self-interests, could turn sand and other raw materials into just the perfect computer, delivered right to my door, ready for producing testimony.

But economists also know that there are circumstances in which the magic of the marketplace breaks down. Almost every one of those circumstances applies in the markets for health care and health insurance. That doesn't mean that we shouldn't try to unleash market forces to control costs. It does mean, however, that an unregulated insurance market will fail to provide insurance for many millions of Americans, including those who are most vulnerable. If there is a role for government in any market, there is a role here.

The Achilles' heel of the health insurance market is adverse selection. When I buy a computer, the seller knows how much it will cost to supply it. The seller offers it for cost plus a modest profit and I buy it if it is worth at least that much to me.

For health insurance, the situation is completely different. Most people would like to have insurance if they can get it at a reasonable price because it protects them from a

major financial risk. But, because of adverse selection, those who most value health insurance will have trouble finding affordable insurance in the nongroup market.

Insurers have imperfect information about the health status of their customers. And the voluntary nature of health insurance complicates the market further. The people who choose to buy insurance will tend to be those who expect to have the highest health care costs. An insurer that offered insurance to all comers (something that most states do not require insurers to do) would have to charge higher premiums to account for the greater likelihood of attracting high-cost enrollees. The higher premiums, in turn, would dissuade additional healthy people from buying insurance. As the health status of the pool of covered people eroded, premiums would get higher and higher, making it even less attractive to relatively healthy people. In the extreme, this "death spiral" could cause the insurance market to self-destruct altogether (Rothschild and Stiglitz 1976).

In fact, it doesn't work out this way because insurers are not passive in this process. They profit most if they can attract a healthier-than-average customer base. Newhouse (1996) documented how insurers exclude preexisting conditions and use other methods to attract the healthiest individuals. The consequence is that the nongroup health insurance market, ironically, only works for healthy people. If you are sick and need health insurance and you don't get it at work or through a public program, you are out of luck.

One might think that purchasing insurance when healthy and maintaining continuous coverage would guarantee affordable insurance when the insured person becomes ill, but it doesn't work that way in practice, despite the guarantee of renewability. The problem is the way insurers set premiums in the nongroup market. Those who purchase a nongroup policy are included in a pool with other policyholders who purchase the same product at the same time. The original premium is low because underwriting guarantees that the original pool is healthier than average. Future premiums depend on the experience of people in the group. Eventually, some people in the group become ill and the premiums start to rise. Healthy people in the group discover that they can pay a lower premium if they buy into a new, healthier group. (Sometimes their own insurer will offer them a lower premium for a new policy.) As healthy people drop out of the group, premiums start to rise very fast for those who have no other alternative—like a person who has developed diabetes. The consequence is that those who get sick either end up paying very high premiums or find insurance unaffordable and drop coverage altogether (Hall 2000).

I should note that insurers are not doing anything different from other businesses. They are simply seeking to maximize profits. Indeed, an insurer that decided to "do the right thing" and offer affordable insurance to people with serious health problems would go bankrupt. The premiums would not come close to covering the health care costs.

When the market works, as in the market for my laptop computer, many producers compete to sell a product that will be most appealing to consumers. The people who value computers most can find exactly what they are looking for at a fair price.

The private nongroup health insurance market does not, and cannot, produce this wonderful result. The decentralized system of firms trying to make a profit and consumers trying to get a good deal results in very little insurance being sold, and mostly

to the people who need it least. Less than 6 percent of workers are covered by nongroup health insurance (table 1). More than three times as many (19 percent) are uninsured. People who most need health insurance often cannot find insurance they can afford.

Also, administrative loads are higher; information for consumers is highly imperfect (widely varying benefit packages make price comparisons difficult, if not impossible; many buy policies without fully understanding what is covered or excluded), and many states allow insurers to use benefit exclusions to deny coverage on particular body parts and body systems related to preexisting medical conditions. Also, in the nongroup market, insurers view an individual looking for a comprehensive policy typical of those available in the group market as someone signaling an intent to use significant amounts of medical services. As a consequence, comprehensive policies are priced high to account for expected adverse selection, leaving policies with higher deductible and cost-sharing and more limited benefit packages as the only affordable options. But such policies are of little value to those with significant health care needs and to those with lower incomes, who often cannot afford the cost-sharing requirements.

Poorly Designed Tax Credits May Undermine ESI and Reduce Insurance Coverage

Of course, despite the nongroup market's flaws, covering several million more people in that market would seem to be a step in the right direction, even if most of the 47 million uninsured remain uncovered. The problem is that a poorly designed tax credit could cause millions of those with ESI to lose coverage and some of them, especially those in poor health or with low incomes, will not be able to afford coverage in the nongroup market.

Subsidizing private nongroup insurance makes employment-based insurance relatively less attractive. Of special concern are proposals that *only* make the credit available in the nongroup market, such as President Bush's early tax credit proposals and H.R. 914. This could cause many employers to stop offering coverage, because their employees could only benefit from the credit if they don't get ESI. But even a neutral credit that applied equally to ESI and nongroup insurance would tend to undermine employer-based health insurance, especially at small firms, since it would eliminate the relative tax advantage for ESI.

Due to higher administrative loads and higher year-to-year variability in group medical expenses, smaller employers often face higher health insurance premiums than do large employers—a major reason why they are least likely to offer coverage now. In addition, their employees tend to have lower incomes, making the value of a tax-free fringe benefit low, and those employees cannot afford to sacrifice much in wages in exchange for insurance. If tax credits are available for nongroup insurance, business owners would no longer have to offer insurance to their employees to qualify for a tax break on their own health insurance. The owners could simply purchase insurance in the nongroup market. Healthy employees are also likely to prefer that their employers stop offering insurance under these circumstances, because they would be able to get a better deal in the nongroup market, where healthy people face very low premiums, and still qualify for a tax subsidy. In response to these new incentives, some employers who currently offer health insurance would "cash out" this benefit, boosting their workers' wages by what they spent on health insurance and telling those who want to retain coverage to buy it in the individual market using the new tax credit to offset part of the

premium. Many firms, particularly larger ones, would still offer insurance because of the combination of convenience, administrative cost savings, and pooling afforded by large groups of people subject to relatively little adverse selection. But firms currently near the margin between retaining and dropping insurance would be likely to drop.

The adverse effect on the employer-sponsored system raises concerns not just because of fragmented risk pools and adverse selection. Many individuals likely sign up for coverage because it is easy and almost automatic when administered through their employers. Put them in the individual market where search costs for an appropriate policy are relatively high, underwriting requires a medical exam, and payments are not automatically deducted from payroll, and many might make the short-sighted choice to forgo insurance (and potentially impose costs on others who pay the cost of uncompensated care through higher premiums or taxes).

The bottom line is that without reforms to the nongroup market and substantial subsidies for low-income households, many people currently insured would likely lose their coverage if tax credits are offered for nongroup insurance. Those who lose coverage would tend to be the most vulnerable—those with low incomes and serious health problems—while those who gain coverage will tend to be those who are healthy. In my view, that would be a poor trade.

Health Insurance Subsidies and Health Care Costs

Expanding coverage is not the only motivation of health market reformers. There is also an urgent need to rein in the growth of health care costs, which have been continually growing much faster than incomes. Indeed, health cost inflation and health insurance coverage are linked. Rising health care costs translate into higher health insurance premiums, which prices health insurance out of the reach of more and more workers.

Insurance gives individuals an incentive to use too much health care because they have to pay only a fraction of the cost (the deductible and coinsurance). They will thus be willing to undergo medical procedures or take expensive prescription drugs even if they are of little value because the insured persons out-of-pocket cost is very low or even zero. To counteract this tendency, many insurers rely on managed care schemes that limit unnecessary medical expenditures.

But how much of the cost of medical care is due to this moral hazard that arises from the low net-of-insurance price of insured care? Newhouse (1992) argues that the lion's share of growth of health expenditures stems from advances in medical technology, not moral hazard. He concludes that overzealous efforts to limit moral hazard could do more harm than good if they reduced the incentive for medical innovation.

Nonetheless, the tax exclusion for ESI clearly creates an incentive to acquire overly generous health insurance coverage as it lowers the after-tax cost of health insurance by as much as 35 percent for taxpayers in the top income tax bracket (and even more when savings in payroll taxes and state income taxes are considered). At the discounted price, consumers may demand more comprehensive insurance with lower copayments and deductibles, and less aggressively managed care.

Several policy responses have been put forward to offset this incentive to purchase overly generous care. The generous tax subsidies for HSAs are one such approach, intended to encourage the purchase of health insurance plans with high deductibles. However, the high-deductible health plans (HDHPs) may not be the best way to control costs. For one thing, they encourage the risk segmentation of the market, as they are most attractive to healthier-than-average people, for whom the high deductibles are a good bet. If employers offer both HDHPs and traditional insurance, adverse selection will tend to make premiums for traditional insurance higher and higher over time.[11]

But if HDHPs supplant insurance with lower deductibles, they could ultimately reduce coverage, especially for those with low incomes or chronically poor health. The $2,200 deductible for family coverage in 2007, for example, would represent a significant financial risk for a low-income household. If that were its only insurance option, the family might opt to refuse health insurance coverage altogether. It would also represent a substantial hardship for someone with a chronic illness who knows that he or she will exceed the deductible every year.

What's more, HDHPs might not even be a particularly effective means of controlling health care spending. Most health care spending is done by a small number of very sick people. Berk and Monheit (2001) reported that 70 percent of health care spending is attributable to only 10 percent of individuals. Blumberg (2007b) calculated that 97 percent of health care costs are incurred by individuals who spend more than the deductibles in HDHPs. Once individuals reach the deductible, insurance pays all additional costs and they have no more incentive to economize than anyone else with insurance. As a result, HDHPs and HSAs are unlikely to have a substantial effect on overall medical spending.

The president's proposed standard deduction for health insurance represented an innovative approach to balancing adverse selection and moral hazard. The proposal would provide a fixed subsidy solely for acquiring insurance that met minimum standards. More expensive insurance would not qualify for a larger subsidy. This approach would encourage individuals and families to get insurance while preserving a strong incentive to shop for a low-cost plan. The deduction is problematic since it retains the upside-down subsidy structure discussed above, but if the deduction were converted to a refundable credit and the individual nongroup market reformed as discussed below, this proposal could encourage consumers to get insurance without encouraging excessive consumption. What's more, if HSAs were eliminated, this option would remove the bias in favor of HDHPs over other possibly more effective means of controlling costs, such as managed care.

Recommendations

Replacing the ESI exclusion with a progressive refundable tax credit would be an improvement over current tax law. Such a credit could turn the upside-down subsidy right side up. It could be designed to provide the largest subsidy to low-income households who most need help, even if they do not owe income taxes. That would encourage more

low-income employees to take up employers' offers of insurance, and would encourage more employers—especially small firms—to offer insurance. Since young, healthy people are more likely to have relatively low incomes, a refundable credit would also encourage more healthy people to take up their employers' offers of insurance, lowering average premiums.

It would also be a good idea, as the president proposed in his State of the Union address in January 2007, to make the subsidy amount depend only on having qualifying insurance, not on the amount of the insurance premium. This would encourage households to gain insurance coverage while retaining an incentive for cost-containment, whether through high deductibles, aggressively managed care, or some other means.

A credit for nongroup insurance alone, as in H.R. 914 and the president's earlier tax credit proposals, would likely do more harm than good. It would cause some employers, especially small ones, to stop offering health insurance, and would likely cause many people with health problems or low incomes to lose their health insurance coverage.

A credit for ESI *and* nongroup insurance could represent an improvement if the inherent problems in the nongroup market can be solved (Blumberg 2007a). There are several possible approaches to doing this. One would be to set up, either at the national level or within each state, a pool of insurers that promises to take all comers in exchange for being able to sell insurance that qualifies for the tax credit. An example of such an arrangement is the Federal Employees' Health Benefits Program, which includes a set of insurers that offer insurance that meets minimum actuarial standards and charges a community-rated premium in each market to any federal employee who chooses their product.[12] There is still the potential that adverse selection would drive up premiums in the purchasing pool if the credit is small. However, if the credit is large enough, then even healthy people would want to buy into the publicly sponsored pool, which would help keep premiums affordable.

Alternatively, or as a complement to state efforts, insurers who wished to sell nongroup insurance that qualifies for the tax credit could be required to offer insurance that is fully renewable and portable (Burman and Gruber 2001). Individuals who maintained continuous coverage through employer-sponsored insurance or qualifying insurance offered in the nongroup market would be guaranteed that they could purchase insurance from any participating insurer at the lowest rates available, even if their health status worsens. This option would give healthy people a strong incentive to purchase insurance, because they would be guaranteed that they could get affordable insurance when they got sick and they would qualify for a tax subsidy. This strong incentive for healthy people to participate would help keep premiums for qualifying insurance relatively low, as they are in large employer groups. Insurers might try to undermine the pooling arrangement by attempting to cherry-pick healthy individuals, but that might be deterred by federal or state regulation of qualifying insurance.

Some issues would need to be addressed if a tax credit is to help many poor families gain insurance. First, the credit would need to be much larger than has so far been proposed. The premium for employer-sponsored family coverage in 2007 averages almost $12,000. That is over 25 percent of pretax income for a family of four earning 200

percent of the federal poverty level.[13] It is likely that for such families, the credit would need to equal 75 percent or more of the premium to induce substantial participation. The Health Coverage Tax Credit, which covers displaced workers who lose their health insurance, covers 65 percent of premiums, and only 11 percent of qualifying individuals take the credit.[14]

A second issue is getting the credit to workers when they need the money. Almost all tax credits are claimed after the end of the calendar year, when a household files its tax return.[15] For a major expense, such as the cost of family health insurance coverage, a lower-income household would have great difficulty advancing the premium, even if it knows that most of the cost would be refunded at tax time. To deal with this problem, the HCTC is paid directly to health insurers. If the credit is available for both ESI and nongroup insurance (as I recommend), it should also be payable in advance to employers who sponsor health insurance.

A further complication arises if the credit amount is based on income. Current annual income is difficult to predict in advance, especially for low-income families whose attachment to the labor force may be erratic. For that reason, President Bush's proposals have allowed households to elect to claim eligibility for an advance credit based on a prior year's income. This approach may still result in a mismatch between eligibility and subsidy levels for a family whose income is very volatile. When they have great need, for example, because of a job loss, they might not be eligible because prior year's income was too high. It also raises administrative issues for the IRS.

Also, transferable tax credits may be very costly for the IRS to administer. Dorn (2007b) estimates that in FY 2007, only 66 percent of the cost of the HCTC went to pay for health care. The rest went to the IRS (21 percent) and the cost of health plan administration (13 percent).

Finally, if tax credits are an add-on to current subsidies rather than a replacement for the ESI exclusion (as President Bush's proposals were), they could prove to be a very costly way to expand coverage. Burman and Gruber (2005) estimated that a tax credit for both ESI and nongroup coverage could cost $6.50 for every dollar of new insurance purchased, largely because so much of the cost would go to buying up the base—that is, covering people who already have either ESI or nongroup insurance. And those estimates do not include administrative costs.

The most cost-effective approach to expanding health insurance coverage may not be a tax subsidy at all, but expansion of an existing public program, such as Medicaid, S-CHIP, or Medicare. For example, CBO (2007) concluded that most of the children who gain insurance under S-CHIP would otherwise be uninsured. In contrast, Burman and Gruber (2005) estimated that most of those who would qualify for tax credits (whether for ESI, nongroup, or both) would have had insurance even without the tax credit.

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Notes

1. Hadley (2003) estimates that mortality declines by 4.5 to 7.0 percent for people when they gain health insurance.
2. Treasury Notice 2005-86 allows employees a grace period of up to two and a half months beyond the end of the calendar year to submit charges for reimbursement under a health FSA if the employer permits.
3. In contrast, no nondiscrimination rules apply to the provisions of commercially purchased health insurance. The Tax Reform Act of 1986 included a new Section 89, which set out nondiscrimination rules for employee health and welfare benefits, but the new restrictions raised a firestorm of protest among business interests and others and were repealed in 1989.
4. The threshold is 10 percent for taxpayers subject to the individual alternative minimum tax.
5. All of the thresholds are indexed for inflation.
6. If the individual contributions are made through a cafeteria plan, they are also excluded from income for payroll tax purposes.
7. The catch-up contribution limit phases up to $1,000 by 2009. The concept of a catch-up contribution was implemented for individual retirement accounts and defined contribution plans in the Economic Growth and Taxpayer Relief and Reconciliation Act of 2001 based on the logic that women had to make additional contributions to catch up for the time spent out of the labor force. This is a dubious justification for a provision that mostly benefits men, and its application to HSAs is truly puzzling since their ostensible purpose is to offset unusually high medical expenses, not provide another retirement savings vehicle.
8. The official government estimates are done for Congress by the Joint Committee of Taxation (JCT) and for the administration by Treasury's Office of Tax Analysis (OTA). Their estimates for the deduction for medical expenses and for health insurance premiums of the self-employed are similar, but their estimates for the exclusion from income tax of ESI diverge markedly. OTA estimates that the latter provision will reduce revenues by $141 billion in fiscal year 2007; JCT estimates a $106 billion revenue loss. The JCT estimates are smaller because they assume that, absent the tax exclusion, individuals who itemize deductions would be able to deduct the part of their health insurance premiums that, combined with other medical expenditures, exceeds 7.5 percent of AGI. OTA does not account for this offsetting deduction because it would logically require an increase in the tax expenditure estimate for the itemized deduction for health expenditures. Note that tax expenditure estimates differ from revenue estimates because, by convention, they do not take into account most behavioral responses or interactions with other tax expenditures. See Office of Management and Budget (2007) and JCT (2007).
9. Payroll tax revenue losses are more than half of the income tax revenue cost. (See Burman et al. 2003). Thus, conservatively, the payroll tax expenditure would be at least $70 billion, based on Treasury numbers, or $53 billion, based on JCT's estimates. This yields a range of $159 to $211 billion or more for the combined revenue loss.
10. HIPAA requires insurers to offer insurance to terminated employees who have exhausted their COBRA coverage, but insurers can and do charge much higher rates for HIPAA customers. For example, CareFirst (Blue Cross–Blue Shield) charges a markup of about 80 percent for HIPAA coverage in Virginia compared with otherwise identical underwritten policies (http://www.carefirst.com, October 8, 2006).
11. To see why, consider the story of Blue Cross high option health insurance. For years, federal employees had a choice of "high option" Blue Cross health insurance and a standard option with a slightly lower deductible and a few other limitations. For the typical federal employee, the high option was worth a little more, and initially premiums were slightly higher. Young, healthy employees risked having to pay the higher deductible in exchange for the small premium difference. Older, sicker employees preferred the high option. But the premium difference grew larger over time as more healthy people shunned the high option. When last offered in 2001, the Blue Cross high-option family premium was $1,500 more than standard option. In 2002, the high option was discontinued.

12. The minimum actuarial standard is necessary to prevent insurers from cherry-picking—designing policies that are most attractive to healthier-than-average employees. The advent of high-deductible plans that qualify for HSAs may have undermined this policy, although it is too early to tell.

13. The average premium for family coverage offered through employers is an estimated $11,790 in 2007. The federal poverty level for a family of four in 2007 is $20,650.

14. There are other issues with HCTC, as discussed in Dorn (2007a).

15. The EITC allows advance payments through employers, but almost nobody takes advantage of this option (GAO 2007). The HCTC provides payments directly to health insurance providers, although there is a delay before payments begin (Dorn 2007a).